NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SECOND ANNUAL REPORT

JULY 30, 1974

National Professional Standards Review Council

SECOND ANNUAL REPORT—JULY 30, 1974

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF PROFESSIONAL STANDARDS REVIEW

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

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INTRODUCTION

Public Law 92-603, the Social Security Amendments of 1972, mandated the establishment of the National Professional Standards Review Council as a part of the Professional Standards Review Program. The Council, approaching its second year of existence, was chartered in May 1973 and members appointed June 1, 1973.

Section 1163(f) of the Law requires the Council to report to the Congress and the Secretary of Health, Education, and Welfare at least annually. This document, representing the second annual report, describes the activities of the Council in fiscal year 1974, presents the Council views about major program issues and outlines the Council's plan for fiscal year 1975.

OVERVIEW OF THE NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

As required by the legislation, the National Council is composed of 11 "physicians of recognized standing and distinction in the appraisal of medical practice." A list of the members of the Council is provided in Appendix 1.

The members of the Council were appointed by the Secretary of the Department of Health, Education, and Welfare after recommendations were received from approximately 100 organizations interested in the PSRO Program. The majority were recommended by organizations representing practicing physicians and the remainder by consumer groups and other health care interests. More than 300 qualified physicians were suggested.

The Chairman of the Council, Dr. Ernest W. Saward, was selected by the Secretary from among Council members. The Director of the Office of Professional Standards Review, in the Office of the Assistant Secretary for Health, serves as the Council's Executive Secretary. Staff support for the Council has been provided by the Office of Professional Standards Review.

The duties of the National Council are specified in Section 1163(e) of Public Law 92-603 as follows:

1. Advise the Secretary in the administration of Title XI, Part B of the Social Security Act relating to Professional Standards Review;

2. Provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations, of information and data which will assist such review councils and organizations in carrying out their duties and functions;

3. Review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of Part B;

4. Make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of Part B.

Additionally, Section 1156 requires the National Council, along with the Secretary, to provide technical assistance to PSROs in "utilizing and applying norms of care, diagnosis, and treatment." Information about regional norms are to be distributed by the Council to PSROs and local variations approved by the Council.

During the first year, when the Program has been in the early policy development phase, the emphasis in Council activity has been on advising the Secretary on important policy issues related to implementing the PSRO legislation. In the view of the Council, this has carried a twofold responsibility. The first has been to provide advice on program policies within the requirements and intent of the legislation. The second has been to interpret the needs and views of both the public and the health professions and communicate these to the Administration. A corresponding responsibility, which Council members have unhesitantly assumed on their own, is discussion of the Program with interested groups and persons around the country.

In this early phase of Council existence as a way to focus Council attention on major issues, three temporary subcommittees were formed: one on policy development, one on issues related to data and norms, and one on evaluation. Through these smaller groups, Council members discussed issues with the staff and with consultants and then brought back to the full Council their recommendations. These subcommittees,

however, are not a permanent part of Council structure. In the future, ad hoc groups will be formed as needed to consider particularly timely and significant issues.

The full Council has met eight times this first year. A list of the dates and places of meetings is included in Appendix 2.

PROGRESS OF THE PSRO PROGRAM

At the time of the Council's last report, the PSRO Program was more of a vision than a reality. Meetings were being organized around the country for discussion of area designation. A small staff was in the early phases of work on the policy issues of PSRO development. The Council had met only once.

As this report is submitted, the PSRO Program is a reality. Two hundred and three (203) PSRO areas around the country have been designated. A PSRO Manual, providing guidelines for the development and operation of PSROs, has been issued. 11 organizations have negotiated contracts with DHEW as Conditional PSROs and 91 more as Planning PSROs. In these 12 months, a tremendous amount of activity has taken place which has allowed the Program to reach its current status. The progress of the Program during this year is summarized in Appendix 3.

NATIONAL COUNCIL ACTIVITIES IN 1974

During this busy year when the PSRO Program advanced to operational status, the National Council took an active part in the development of policy. During Council meetings major policy issues were presented, debated, and recommendations made. While considerable progress has been made in resolving major issues, as documented by activities of the Program during this year, it has also become increasingly clear that many of the issues involved are exceedingly difficult. Where resolution has not been possible, it is important to note that during the course of the year the requirements of the legislation and the significant issues have come into better focus. The major issues considered by the Council and the Council's major activities are summarized in the pages that follow.

1. Area Designation

   Area designation policy was a significant issue for the Council. At the Council's first meeting, the staff presented policy guidelines on Area Designation. The point of controversy centered around the guideline that specified a minimum (300) and maximum (2500) limit in the number of physicians in a PSRO area.

Council Recommendation: A Council motion was approved that inserted the work "generally" into the guideline to lend flexibility to its application. The guideline then read as follows:

> "A PSRO area should generally include a minimum of approximately 300 licensed practicing physicians. While the maximum can be expected to vary with local circumstances, it generally should not exceed 2500 licensed, practicing physicians."

In addition, the Council adopted a position statement which reads as follows:

> "It is clear that area designation considerations within a State recognize that appropriate geographic sublimits within the State with the capability to develop a PSRO meeting law and regulatory requirements can seek, and can be expected to obtain, area designation.
>
> It is recognized that there are approximately 29 States with less than 3,000 physicians and it is acknowledged that the Secretary could, if desirable, designate the entire State in such case as a single PSRO area.
>
> At the same time, in any of the approximately 21 other States where the professional association (s) concerned demonstrate a desire and capability of successfully sponsoring a State level PSRO, the option of a "statewide" area designation or an area designation encompassing the remainder of the State could be considered even though the 2,500 physician general limit (Guideline #5) is exceeded. Under either option the State level PSRO would contract directly with DHEW to coordinate and administer all professional review functions within its purview, with the actual review performed locally throughout the designated area."

Effect of Council Action: In a few States where there was consistency with other policy guidelines, statewide PSROs that exceeded the 2500 physician limit were allowed. In addition, many of the functions that the Council envisioned for Statewide PSROs were incorporated into the concept of Statewide PSRO Support Centers.

2. Norms, Standards, and Criteria

The review methods to be used by PSROs and the development, distribution, use and modification of PSRO norms, standards, and criteria have been of continuing interest to the Council. Council members worked on these issues with the staff and with outside groups, such as the American Medical Association's Task Froce on PSRO Guidelines and national physician specialty societies. One of the earliest actions of the Council was to adopt precise definitions for the terms "norms," "standards," "criteria," and "screening."

Council Recommendation: On November 26, 1973, the Council adopted the following definitions:

> "Norms -- Medical care appraisal norms are numerical or statistical measures of usual observed performance.
>
> Criteria -- Medical care criteria are predetermined elements against which aspects of the quality of a medical service may be compared. They are developed by professionals relying on professional expertise and on the professional literature.
>
> Standards -- Standards are professionally developed expressions of the range of acceptable variation from a norm or criteria.
>
> Screening -- Screening is a process in which norms, criteria or standards are used to analyze large number of cases in order to select for study in greater depth those cases not meeting the norms, criteria or standards."

Effect of Council Action: The definitions have become an integral part of PSRO terminology.

3. PSRO Data

The issues involved in developing an effective data policy for the PSRO Program have concerned the Council throughout the year. Of major importance was the work accomplished in identifying a minimal data set for use by PSROs. Such a data set will be part of the claims forms for both Medicare and Medicaid and will be an essential part in the development of provider and patient profiles. Additionally, it will be important in PSRO evaluation.

Another significant area of Council activity in data policy related to coding systems. Sets of criteria, or parameters,

that could be used to analyze existing or new coding systems were determined to be necessary. The relationship of this activity to the Department's international collaborative effort in coding was recognized.

Additionally, the Council considered the subject of baseline data. The need to collect preoperational data was stressed.

Council Recommendations: On November 26, 1973, the Council adopted the Uniform Hospital Discharge Data Set (UHDDS),[1] as expanded for PSROs, as the minimal data set. Council position was that the UHDDS should be truly a minimal set that could be expanded.

At the meeting on January 21, 1974, the Council approved sets of coding criteria that had been developed for diagnostic coding systems and for procedural coding systems. The Council also recommended to the Secretary of Health, Education, and Welfare that these coding criteria sets be used in other Department efforts as well. Additionally, the Council adopted the following motion:

> "It is recommended that the National Professional Standards Review Council urge the Secretary of the Department of Health, Education, and Welfare to provide leadership in the formation of a group having the representation of interested parties, with the necessary supporting staff resources, to study and evaluate existing terminology, nomenclature, classification and coding systems and to recommend a uniform coding system or, failing that, a set of compatible systems for the recording and retrieval of clinical and health-care related data."

On June 11, 1974 the Council adopted the following motion related to baseline data:

> "The NPSRC recommends to the Secretary that agencies and intermediaries making payments for services under Titles V, XVIII, and XIX be instructed now to collect and be able to display the following data for each PSRO area:
>
> (1) Rates of hospital admissions per quarter by age and sex for the populations at risk.
> (2) Diagnoses (up to 3) for each hospital admission as they appear on the payment request.
> (3) Length of stay, linked to diagnosis and/or procedure, for each hospital admission."

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1. The Uniform Hospital Discharge Data Set is based on the work done by the Uniform Abstract Subcommittee of the United States National Committee on Vital and Health statistics, the Uniform Hospital Discharge Data Demonstration, and the Work Group on Uniform Hospitalization Data for HEW programs.

Effect of Council Action: The Uniform Hospital Discharge Data set has been approved by the Secretary and is being used as a base in determining minimum data requirements. The Department through an internal group has been working on coding systems and in the near future will be establishing an external group as recommended by the Council. Finally, the Department is investigating the technical feasibility of the recommendation of June 11.

4. Preadmission Certification

A continuing concern of the Council has been preadmission certification or prior authorization of hospital admissions. The objections to prior authorization systems were based on evidence from current review programs indicating that such systems are not of superior effectiveness and often are of undue disruption to effective review mechanisms.

Council Recommendation: At the November 26 meeting, the Council stated their position on preadmission certification.

> "That the National Professional Standards Review Council recommend to the Office of Professional Standards Review that emerging PSROs be informed of acceptable, alternative review mechanisms for determining the medical necessity of admission to institutions, and that the stated objectives of the National PSR program recognize such effective alternatives to preadmission authorization."

At the following meeting on January 21, the Council reaffirmed this opposition and specifically directed their recommendations to Title XVIII and Title XIX requirements.

> "That the National Professional Standards Review Council inform the Secretary of HEW of strong opposition to implementation of a program of mandatory preadmission certification for hospital services delivered under Title XVIII and Title XIX.
>
> That National Professional Standards Review Council request the PSRO program to develop a system of hospital review based upon concurrent review with retrospective studies as indicated."

Effect of Council Action: The emphasis in PSRO review requirements developed by the Department has been on concurrent review, consistent with Council action.

5. Statewide PSRO Councils

The Council spent considerable time on policy issues related to Statewide Professional Standards Review Councils. The following issues were considered: the role of Statewide Councils, how and when they are to be established, organizational requirements, and criteria and procedures for selecting members.

Council Recommendations: The Council provided the following specific advice regarding the membership of Statewide Councils:

- a consumer should be a member;
- representation of the State Medicaid agency should be encouraged;
- in addition to the State affiliate of the American Medical Association, the State affiliate of the American Osteopathic Association should be considered as the second medical society designee in those States with a significant number of osteopathic physicians;
- hospital association representation on the Statewide PSR Council should be interpreted to relate primarily to affiliates of the American Hospital Association;
- each PSR Council should elect its own chairman.

In addition, other recommendations were made as the Council reviewed the draft of the chapter in the PSRO Manual relating to Statewide Councils. These recommendations related both to the language used in the chapter and to substantative policy issues. Substantative changes were recommended in the procedures for appointing members and in the functions of the Council. The Council states that in its view the role of a Statewide Council was one of coordination and liaison, not management.

Effect of Council Action: Recommendations of the Council are being incorporated into the requirements for Statewide PSR Councils as written in the PSRO Manual.

6. Local Development of Criteria

The Council has been sensitive to the concern that national norms, criteria, and standards might be imposed on PSROs from a national level. The Council acknowledged on one hand, the valuable work being done by various organizations in the development of model screening criteria sets. On the other hand, however, the Council felt it was important that PSROs learn the process of criteria development and noted that locally developed criteria have a better chance of being internalized by those involved.

Council Recommendation: The Council expressed the view that nationally developed model screening criteria sets should be reviewed by the Council and, if determined to be useful to PSROs, should be distributed to them. Such model sets would serve as guidelines for local areas and would need to be adapted and modified by the PSRO to fit the local situation. Every necessary assistance should also be given to PSROs in developing their own criteria as the Council expressed in the following motion:

> "The National Council take an active initial role in PSRO development by providing, through the Department, leadership in the local development of norms, standards, and medical-care criteria to beginning PSROs."

Effect of Council Action: The Department continues to stress local development of criteria and will be providing technical assistance to PSROs as desired by the Council.

7. Evaluation

During the course of the year, the Council has devoted considerable attention to the development of an evaluation plan for the PSRO Program. The Evaluation Subcommittee worked closely with the staff, sought the advice of consultants, and frequently worked jointly with the Subcommittee on Data and Norms. The first major task in developing an evaluation strategy was the specification of national program goals. Currently, the Subcommittee is working with the staff on identifying the specific PSRO activities on which evaluation will focus.

Council Recommendation: After development by staff and review and modification by the Evaluation Subcommittee, the Council adopted a statement of major goals for the national PSRO program.

MAJOR GOALS OF THE NATIONAL PSRO PROGRAM

I. Goals Related to Quality of Service

A. To assure that services for which reimbursement is claimed meet or exceed a reasonable standard of quality for health services to all beneficiaries of the covered programs.

B. To assure that high quality care is achieved through proper use of health care practitioners in terms of their competence.

II. Goals Related to Resource Allocation

A. To assure that beneficiaries are admitted to suitable types of health care institutions when such admissions are required by their health problems, and for periods of time as are necessary for the proper medical managment of their health problems.

B. To assure that the health care services received by beneficiaries are appropriate to their health problems.

C. To promote the efficient use of services, facilities and personnel in the provision of medically necessary health care.

III. Goals Related to Program Implementation and Acceptance

A. To determine if the cost of establishing and operating the PSRO program is commensurate with its impact on the utilization and quality of health care services.

B. To assure reasonably prompt PSRO coverage of health care services reimbursed under Titles V, XVIII, and XIX.

Effect of Council Action: The program goals adopted by the Council are serving as a base for the further development of an evaluation plan.

8. PSRO Manual

Development of the PSRO Manual was a major program activity this year as it includes the guidelines for PSRO development and operation. The Council reviewed each of the chapters of the Manual as they developed, discussed them with the staff and recommended changes.

Council Recommendations: The Council recommended numerous changes in each of the chapters it reviewed. Changes both in language and substantative matters were involved. The draft chapters reviewed included the following:

Introduction to the Manual
Organizational Requirements of PSROs
Application Process
Statewide Councils
Advisory Groups
PSRO Health Care Review Responsibilities
Baseline Data
Federal Reporting Requirements

Effect of Council Actions: Changes recommended by the Council were incorporated into the Manual by the Staff.

9. Communication with National, State and Local Organizations

In addition to attending the frequent Council and subcommittee meetings, Council members, on their own, have undertaken extensive speaking engagements to discuss the PSRO Program. Meeting with concerned groups in their own community and State and also traveling extensively around the country, members have conveyed information about the intent of the legislation and the progress and nature of program implementation.

Council activity continues in several areas as this report is being developed. The development of an evaluation strategy proceeds with Council advice and guidance. A data policy for the program is being formulated and Council members are reviewing the elements of such a policy and contributing their views. The Council is working with the staff to develop an appropriate role for PSROs in continuing health education. Discussion of the relationship between PSROs and the medical review boards of the End Stage Renal Disease Program and between PSROs and Health Maintenance Organizations is beginning. These activities will continue into Fiscal Year 1975.

COUNCIL PLANS FOR 1975

Fiscal Year 1975 is anticipated to be one of growth for the PSRO Program. It will also be a crucial year for the Program. PSROs will be operational and many individuals and organizations will be watching closely for signs of success or of failure. Difficult, and sometimes controversial, issues involved in implementation will have to be resolved.

The National Council will be involved in these 1975 activities. Again, the major emphasis will be on providing advice and guidance to the Department and conveying to it the needs of the public and the health professions. As the Program becomes operational, the Council will also begin to carry out those additional responsibilities that are mandated by the legislation.

1. Advice to the Secretary

As the Department carries out policy development and implementation activities, the Council will discuss the issues with the staff and offer advice and direction. Anticipated areas of Department activities and Council advice for 1975 are summarized below:

- development and issuance of the remaining chapters of the PSRO Manual: these include (1) PSRO Data Needs and Processing; (2) Relationships with Medicare and Medicaid Contractors; (3) Disclosure of Information; (4) Reconsideration, Hearings and Appeals; (5) Application of Sanctions; (6) Statewide Professional Standards Review Councils; (7) PSRO and Statewide Council Advisory Groups; (8) National Professional Standards Review Council; and (9) PSRO Program Monitoring and Evaluation;

- assistance to PSRO organizations: this will involve (1) the further awarding of contracts to PSROs and Statewide PSRO Support Centers and the negotiation of agreements with Statewide PSRO Councils, and (2) the training of physicians, other health professionals, and administrators to operate PSROs;

- further development of policies and procedures for PSRO review activities: issues will include (1) review in long-term care facilities, (2) review of ambulatory care, (3) alignment of the Joint Commission on the Accreditation of Hospitals and American Hospital Association quality assurance system with PSRO review requirements, and (4) development of model sets of screening criteria under contract with the American Medical Association and others;

- further development and implementation of PSRO data policy: included will be (1) PSRO data flow models, data review requirements, Uniform Hospital Discharge Data Set implementation plan, and initial monitoring and evaluation plan, (2) policy for data acquisition and systems use, (3) policy on confidentiality of information, and (4) minimum data sets for long-term care and ambulatory care;

- further development of financial management and financial reporting guidelines;

- completion of an evaluation plan and its initial implementation;

- development of appeals procedures;

- development of guidelines for coordination of PSRO activities with Medicare and Medicaid.

2. Assistance to PSROs and Statewide Councils

The Council, through the resources of the Department, will assure that PSROs and Statewide Councils are given every possible assistance. This assistance will include training programs for those involved in PSRO operations and providing PSROs with a variety of forms of technical assistance and consultation as well as relevant information and data. Additionally, the National Council has a special mandated responsibility to see that PSROs are given help in utilizing and applying norms.

Having the necessary resources is critical for successful PSRO performance and the Council is committed to seeing that these are provided. The Council will be developing mechanisms to assure that these resources are provided and to keep in touch with PSROs so that there can be an awareness and a responsiveness to their needs.

As a specific way to assist PSROs, the Council will be organizing and sponsoring a national conference on quality assurance and peer review. This conference will be in the Fall of 1974 and will involve health professionals from throughout the United States.

3. Evaluation

A major activity of the Council in 1975 will be in the area of evaluation. The Council will be working with staff to develop methodologies to evaluate the impact of the PSRO program on the quality of care provided under Titles XVIII, XIX and V of the Social Security Act and to evaluate individual PSRO and Statewide Council effectiveness and comparative performance. This year the Council and the Department were laying the groundwork for these evaluation activities through the careful development of an evaluation strategy for the Program. As these activities continue and expand, the Council will utilize the expertise of both staff and consultants. The Council hopes that it will be able to determine how and where the quality of care has been improved and then to use this information to improve patterns of medical care.

4. Recommendations for a More Effective Program

During 1975, as the Program obtains operating experience and information, the Council may want to suggest to the Secretary and to the Congress some modifications in the legislation. If information received during the course of the year indicates a

need to examine any basic requirements of the Program, appropriate investigations will be undertaken.

5. Communication with the Nation's Health Professionals and Public

While not a legislatively mandated function, the Council feels it has a special responsibility to communicate the nature and activities of the PSRO Program to the public and to the Nation's health professions. The Council, as a unit, and Council members, as individuals, will continue to assess the need for information and education and will respond to it.

The Council will also continue to perform an advocacy role on the part of the public and the Nation's health professionals. Their views will be interpreted in light of the legislation and communicated to the Department.

SPECIAL ISSUES OF IMPORTANCE TO THE PROGRAM

The Council believes there are several issues of special importance to the success of the PSRO Program. 1975 will be a critical year for PSRO and how the following issues are handled by the Department may determine, to a great extent, the Program's future.

1. Support of the Nation's Physicians

An earlier section of this report presented the support that the Program has generated from organizations of physicians. While it is clear that these groups represent the majority of the Nation's physicians, it is necessary to recognize that sizeable numbers of practicing physicians oppose PSROs. The Council, believes that in many instances this opposition is based on misinformation and ignorance of the facts about the legislation and how it is being implemented. In numerous instances, where physicians have understood what the Law really contains and how the Department is implementing it, opposition turned to support. Therefore, the development of more effective approaches to reach physicians with accurate information and to allay their fears is important.

2. Confidentiality of Information

How the Program handles the issue of confidentiality of information is particularly important. The Council is concerned about the need for maintaining the confidential nature of data and information used by PSROs.

Obviously, PSROs will need access to sensitive medical information if they are to perform their job in an effective manner. The statute includes a strict provision against disclosure of PSRO data or information except as may be needed for PSRO purposes or in such cases or under such circumstances as the Secretary of HEW will provide through regulations. The Department has stated its firm intent to develop and issue strict regulations to assure that any data that the PSRO gathers will be held in the strictest confidence and used only for the purposes specified in the Law. These regulations are now under development.

3. The Complexity of the Program

Implementation of the PSRO legislation represents a complex undertaking. Not only are the requirements of the legislation itself extremely involved but also each of the Programs that PSROs must review are in themselves complex. Medicare, Medicaid, and Title 5 Programs have separate benefit structures, payment mechanisms, and organizational and administrative arrangements. This is particularly true of Medicaid which has 53 distinct programs.

The problem of complexity is compounded by other additions to the Social Security Act. The new utilization review requirements, program review teams, and procedures for hearings and appeals, as examples, are all related to PSRO function and operation and will require integration.

This complexity has made the task of policy development exceedingly difficult. Now, as individual PSROs begin to develop themselves, they will be faced with the even more difficult task of integrating the operations of these programs at the local level. The development of effective working relationships between each PSRO and this myriad of organizational entities will be an important factor in the eventual success of the Program.

The nature of the data required for PSRO review and how they are to be handled is an important subset in this area of program complexity. Each of these programs now has its own data requirements and systems and major differences exist even within the same program. The development of a PSRO data policy that effectively integrates this multitude of approaches and, at the same time, is not prohibitively costly, requires both skill and restraint.

There is also concern by the Council about other health programs and their relationship with PSROs. The new Health Maintenance Organization legislation and the End-Stage Renal Disease Program,

as examples, are separate pieces of legislation that incorporate quality assurance activities. The integration of these activities into the PSRO structure will be an important future task of the Program.

The Council is pleased to see that many of the national health insurance bills pending in the Congress utilize PSROs for quality assurance and will be observing the progress of this legislation closely. At such a time when there is a program of national health insurance, the challenges for integrating complex program requirements will be even greater.

4. Flexibility of Organizational and Review Requirements

The Council is aware that, while peer review is not a new endeavor, many aspects of the PSRO Program require activity in areas where methodologies are not now available. Additionally, the most effective organizational arrangement to carry out PSRO functions is not known and; in fact, there may be no single best approach. These inherencies in the Program require maximum flexibility in requirements so that innovation and experimentation are allowed to occur.

Concern has been expressed by some that the PSRO Manual appears excessively rigid in its requirements, even though the review system is charscterized by local decision-making. The Department has stressed that the Manual contains guidelines and not regulations and that they can be modified as information becomes available through actual operating experience. Additionally, the negotiating process involved in the awarding of contracts will allow flexibility; and later when an agreement procedure is implemented, this flexibility will be enforced. Nevertheless, concerns remain and require attention.

5. Review Criteria, Norms, and Standards

As discussed earlier under the 1974 activities of the Council, the Council has gone on record supporting local development of review criteria; but this apparently will continue to be an issue as there remains a concern among some that norms, standards, and criteria will be imposed on PSROs from above and will serve as absolute determinants of care.

The PSRO Manual stresses local development of criteria for use as checkpoints to enhance the review process. The Council and the Department have stated and restated their intention that the development of criteria and standards, while taking into account the efforts of national specialty societies and others, is the

fundamental responsibility of local PSROs. Consistent implementation of that policy, together with communication to the Nation's health professionals will be important in changing the attitudes of those concerned. Equally important will be the provision of assistance to PSROs so that they can effectively develop their own criteria.

SUMMARY

The Council believes that 1974 has been a productive year and that the PSRO Program is off to a good start. During this year, the Council has learned how to function effectively and productively and Council members now work well together.

The Council looks forward to implementing the plans included in this report. The difficulties ahead are recognized, as this is a tremendously complex venture, and the nature of the Program inevitably invites divided opinions. Nevertheless, the Council is firmly committed to the goals of the legislation and is optimistic about its success.

APPENDIX

Appendix 1

Membership of the National Professional

Standards Review Council

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

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*Served from June 1973
to March 1974.

** Appointed June 19, 1974,
to fill unexpired term of
Dr. Greene.

Appendix 2

Council Meetings in Fiscal Year 1974

National Professional Standards Review Council
Meetings in Fiscal Year 1974

Date	Place
July 9-10, 1973	National Institutes of Health Building 31, Conference Room 10 Bethesda, Maryland
August 27, 1973	Parklawn Building Conference Room G/H Rockville, Maryland
October 15, 1973	HEW North Building Conference Room 5051 Washington, D.C.
November 26, 1973	HEW North Building Conference Room 5051 Washington, D.C.
January 21-22, 1974	HEW North Building Conference Room 5051 Washington, D.C.
March 4-5, 1974	HEW North Building Conference Room 5051 Washington, D.C.
April 22-23, 1974	HEW North Building Conference Room 5051 Washington, D.C.
June 10-11, 1974	HEW North Building Conference Room 5051 Washington, D.C.

Appendix 3

PSRO Program Progress

PSRO PROGRAM PROGRESS

1. DHEW Organized for PSRO Implementation

During Fiscal Year 1974, the Department of Health, Education, and Welfare delineated responsibilities among its components for the implementation of the PSRO legislation. Overall responsibility for direction of the total Department effort rests with the Assistant Secretary for Health through the Office of Professional Standards Review (OPSR). Under this general direction, the Bureau of Quality Assurance (BQA) in the Health Services Administration (HSA), the Bureau of Health Insurance (BHI) in the Social Security Administration (SSA), and the Medical Services Administration (MSA) of the Social and Rehabilitation Service (SRS) have specific areas of program responsibility.

One hundred and eleven (111) staff positions in the Central Office and thirty (30) staff positions in the Regional Offices were allocated for PSRO activity during 1974. Training programs for staff have been conducted.

2. Relationships Developed with Interested Organizations

Recognizing that support and involvement of health professionals, particularly practicing physicians, is critical to PSRO success, the Department worked to develop effective working relationships with national health organizations. There has been an active effort to keep these organizations informed about the Program and to consult with them as PSRO policies developed.

Both the Department and the Council has worked with the special task forces on PSROs established by the American Medical Association. These task forces have been helpful to the Program in this early phase of policy development. Recently the Department negotiated a contract with the American Medical Association to develop model screening criteria; the major national specialty societies are involved in this effort.

Supportive relationships with other organizations representing the majority of practicing physicians have been developed. Members of the National Council have been instrumental in the development of many of these relationships. The professional societies and academies of all the major specialty groups (family practice, surgery, internal

medicine, psychiatry, pediatrics, obstetrics, and anesthesiology) have taken a position in support of the PSRO Program, have developed special committees to assist PSRO implementation, or along with many other subspecialty organizations, are working on the development of model sets of medical care criteria. Many specialty societies have been engaged in special activities that will be helpful to local PSROs. For example, the American College of Radiology is working on a project to determine the efficacy of five of the most common x-ray procedures. A joint effort by the American College of Physicians, the American College of Surgeons, the American Academy of Pediatrics, the Infectious Disease Society of America, and the American College of Family Practice is being directed at the development of appropriate antibiotic standards. The American Osteopathic Association has been supportive of PSRO since the beginning of the Program. In addition, the American Geriatric Society has been holding regional meetings to consider how they may assist in implementation of the Program. This will be of particular importance in the review of long-term care.

Interns and residents, through the Physicians National Housestaff Association, have taken a position of support of PSROs. Similarly, the Student American Medical Association has urged the medical profession to work toward PSRO implementation.

Extremely helpful during this year has been the American Association of Foundations for Medical Care. Their sponsorship in April of a national meeting for prospective PSROs and other interested persons was an important step in getting the Program operational.

A major private initiative will complement implementation of the PSRO Program. The W. K. Kellogg Foundation has awarded a grant of over $1 million for the study of six prototype PSROs. The American Association of Foundations for Medical Care, the American Medical Association, the American College of Physicians, the American Society of Internal Medicine, and the American Hospital Association are responsible for the conduct of the study.

Extensive consultation has been in progress with the American Hospital Association, the Joint Commission on the Accreditation of Hospitals, and the American Osteopathic Hospital Association. These working relationships are particularly important in the development of review procedures that eliminate duplication of review requirements. Similarly, the importance of working closely with representatives of the country's 20,000 nursing homes has been recognized and consultation is now underway with them for the purpose of unifying PSRO review with the review presently required in the Medicare and Medicaid Programs.

Other health groups have been supportive and helpful as well. Representatives of third party payors have been extremely helpful

in the consideration of data management, evaluation, and reimbursement problems. Communication has been initiated with representatives of teaching institutions, and these organizations are assisting the Program in those problems at the interface of education and peer review. Representatives of health maintenance organizations have been helpful in beginning to define relationships between HMOs and PSROs. Organizations representing health care practitioners other than physicians have also given evidence of support and a willingness to assist in Program implementation.

3. Communication About PSROs

Along with the development of supportive relationships with major national health organizations, an ongoing effort at communicating with all those who are interested in PSROs and who are important to their success has taken place. The OPSR Memo, a periodic publication of the Office of Professional Standards Review which reaches 2,500 organizations, speeches around the country by the Department's leadership and staff and by National Council members, periodic press releases, and distribution of a pamphlet about PSROs to all physicians are just a few examples of the approaches taken.

There has been special emphasis on communication with prospective PSROs and those interested at the local level in working with them. Both Central Office and Regional Office PSRO staff have held hundreds of meetings around the country to explain the Program and elicit comments and suggestions. The American Nurses Association and the American Podiatry Association have been awarded contracts for criteria development.

4. PSRO Areas Designated

The first major task to be accomplished in implementing the PSRO legislation was the designation of PSRO areas. In early 1973, the Department completed guidelines which were used in determining the most appropriate PSRO areas in each State. These guidelines emphasized that areas should not cross State or county lines; that existing review organizations and planning areas should be considered; that medical service areas should be taken into account, as well as the need for coordination with Medicare and Medicaid fiscal agents; and that physician populations should generally range between 300 and 2,500. These were guidelines and not absolute criteria, and they were aimed at assisting local groups and organizations who were participating in the area designation process.

These area designation guidelines were then distributed around the country and used in meetings held by the Department with over 1,000 interested organizations in almost every State of the country. Based upon the discussions at these meetings, the Department issued proposed designation of 182 PSRO areas on December 20, 1973. Over 1,700 comments

were received from a wide variety of interested organizations, and based upon these comments, several changes were made. On March 18, 1974, the final designation of 203 PSRO areas was published. A list summarizing PSRO areas by State can be found in Appendix 4.

5. Concept of Statewide PSRO Support Centers Developed

The concept of a Statewide organization that would stimulate and support PSRO development and operation developed over the course of the year. It was designed to capitalize upon the experience and knowledge of State professional organizations, particularly the State medical societies and foundations. Statewide PSRO Support Centers, as these State level organizations are called, will provide professional, administrative, and technical support to assist local PSROs in carrying out standard setting and peer review responsibilities. These Support Centers are being established through the competitive contracting process.

6. Policy Guidelines Developed

Throughout the year, the development of the initial set of policies and procedures to start the Program has been a primary activity. In mid-March, the PSRO Manual was issued, containing explicit instructions on how organizations apply to become PSROs and on basic PSRO qualifications and requirements. Prior to its publication, the Manual was discussed extensively with the National Council and with major national health organizations.

The first issue of the Manual contained seven of the expected 17 chapters. These chapters covered the subjects of PSRO area designation, Statewide PSRO Support Centers, PSRO Planning organizations, requirements for qualification as a Conditional PSRO, the application and contract process, and PSRO health care review responsibilities.

7. Notification and Polling Regulations Issued

The Law requires that prior to entering into any agreement under which an organization is designated as a PSRO, notice of intent must be given to physicians in the area. If more than 10 percent of the area's physicians object on the ground that the organization is not representative, a poll of physicians must be taken. Regulations governing this provision were developed and published as proposed rulemaking in the Federal Register on April 16, 1974. Final regulations were published May 1, 1974 and became effective May 7, 1974.

8. Contracts Negotiated for PSROs and Support Centers

In March, DHEW announced that it was ready to receive applications for contracts from physician organizations seeking to participate in the PSRO Program. Three types of contracts were involved: (1) planning contracts for those organizations desiring to become PSROs and needing assistance to meet the requirements; (2) conditional designation contracts for those organizations who are ready or nearly ready to implement PSRO requirements, and (3) Statewide PSRO Support Center contracts for organizations to provide assistance to newly formed PSROs in a variety of administrative, organizational and professional matters. Extensive interest was shown as evidenced by the large number of applications received: 104 applications for PSRO planning contracts, 14 applications for PSRO conditional contracts, and 13 applications for Statewide PSRO Support Center contracts.

Applications were carefully reviewed and PSRO Planning Contracts, Conditional PSRO Contracts, and Statewide PSRO Support Center Contracts were awarded. All but nine States will have at least one contract. A list of the organizations awarded contracts can be found in Appendix 5.

9. PSRO Potential Impact Extended by National Health Insurance Proposals

The opportunity for major impact by PSROs on the quality of health care in the United States was greatly extended by legislative events of this year. The Administration's proposal, the Comprehensive Health Insurance Plan (CHIP), places health services provided under CHIP under the review of PSROs. Virtually all of the other national health insurance bills pending in the Congress likewise utilize PSROs for quality assurance.

Appendix 4

Summary of PSRO Areas

NUMBER OF PSRO AREAS DESIGNATED BY STATE

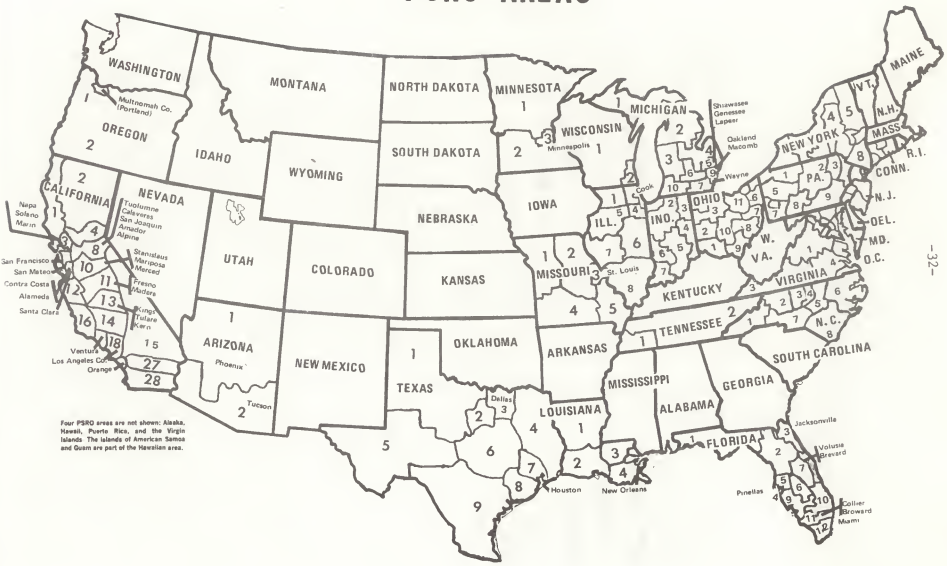
	Final Areas		Final Areas
ALABAMA	1	MAINE	1
ALASKA	1	MARYLAND	7
ARIZONA	2	MASSACHUSETTS	5
ARKANSAS	1	MICHIGAN	10
CALIFORNIA	28	MINNESOTA	3
COLORADO	1	MISSISSIPPI	1
CONNECTICUT	4	MISSOURI	5
DELAWARE	1	MONTANA	1
DISTRICT OF COLUMBIA	1	NEBRASKA	1
FLORIDA	12	NEVADA	1
GEORGIA	1	NEW HAMPSHIRE	1
HAWAII, AMERICAN SAMOA, GUAM TRUST TERRITORIES OF THE PACIFIC ISLANDS	1	NEW JERSEY	8
IDAHO	1	NEW MEXICO	1
ILLINOIS	8	NEW YORK	17
INDIANA	7	NORTH CAROLINA	8
IOWA	1	NORTH DAKOTA	1
KANSAS	1	OHIO	12
KENTUCKY	1	OKLAHOMA	1
LOUISIANA	4	OREGON	2
		PENNSYLVANIA	12
		PUERTO RICO	1

NUMBER OF PSRO AREAS DESIGNATED BY STATE

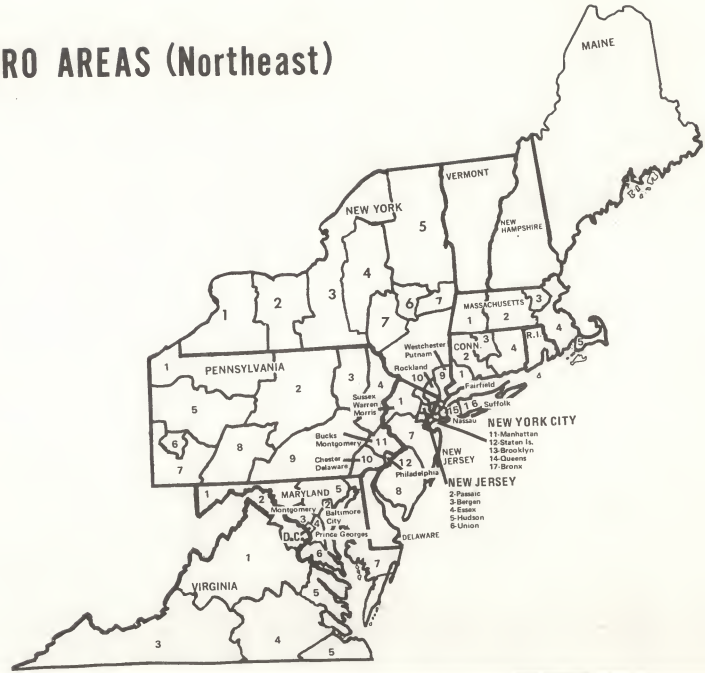
(Continued)

	Final Areas		Final Areas
RHODE ISLAND	1	VIRGIN ISLANDS	1
SOUTH CAROLINA	1	VIRGINIA	5
SOUTH DAKOTA	1	WASHINGTON	1
TENNESSEE	2	WEST VIRGINIA	1
TEXAS	9	WISCONSIN	2
UTAH	1	WYOMING	1
VERMONT	1		
		TOTAL	203

PSRO AREAS


WASHINGTON
Multnomah Co. (Portland)
OREGON
CALIFORNIA
Nepa
Solano
Marin
San Francisco
San Mateo
Contra Costa
Alameda
Santa Clara
Ventura
Los Angeles Co.
Orange
NEVADA
Tuolumne
Calaveras
San Joaquin
Amador
Alpine
Stanislaus
Mariposa
Merced
Fresno
Madera
Kings
Tulare
Kern
IDAHO
MONTANA
WYOMING
UTAH
ARIZONA
Phoenix
Tucson
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
Dallas
Houston
MINNESOTA
Minneapolis
IOWA
MISSOURI
St. Louis
ARKANSAS
LOUISIANA
New Orleans
WISCONSIN
MICHIGAN
Shiawassee
Genessee
Lapeer
Oakland
Macomb
Wayne
Cook
ILL.
IND.
OHIO
W. VA.
KENTUCKY
TENNESSEE
MISSISSIPPI
ALABAMA
GEORGIA
FLORIDA
Jacksonville
Volusia
Brevard
Pinellas
Collier
Broward
Miami
VIRGINIA
N.C.
SOUTH CAROLINA
NEW YORK
PA.
N.J.
DEL.
MD.
D.C.
MAINE
VT.
N.H.
MASS.
R.I.
CONN.
Four PSRO areas are not shown: Alaska, Hawaii, Puerto Rico, and the Virgin Islands. The islands of American Samoa and Guam are part of the Hawaiian area.

PSRO AREAS (Northeast)



Appendix 5

Contracts Awarded Fiscal Year 1974

PSRO Contracts, Fiscal Year 1974

ALABAMA (Single PSRO Area)		
Planning		Alabama Medical Review, Inc. Montgomery, Alabama
ALASKA (Single PSRO Area)		
Planning		Alaska PSRO Anchorage, Alaska
ARIZONA (Two PSRO Areas)		
No contract awarded.		
ARKANSAS (Single PSRO Area)		
Planning		Arkansas Foundation for Medical Care Fort Smith, Arkansas
CALIFORNIA (Twenty-eight PSRO Areas)		
Planning	Area I	Redwood Coast Region PSRO Santa Rosa, California
	Area III	North Bay PSRO San Rafael, California
	Area V	San Francisco PSRO, Inc. San Francisco, California
	Area VI	PSRO of San Mateo County San Mateo, California
	Area XI	Foundation for Medical Care of Santa Clara County San Jose, California
	Area X	Stanislaus Foundation for Medical Care Modesto, California

CALIFORNIA
(Continued)

Planning	Area XII	Monterey Bay Area PSRO Salinas, California
	Area XIV	Kern County Medical Society Bakersfield, California
	Area XVI	Organization for PSR of Santa Barbara/San Luis Obispo Counties Santa Barbara, California
	Area XVII	Ventura Area PSRO, Inc. Ventura, California
	Area XXIV	East Central Los Angeles PSRO Los Angeles, California
	Area XXVII	Riverside County PSRO Riverside, California
Conditional	Area VIII	San Joaquin Area PSRO Stockton, California
Support Center		United Foundations for Medical Care San Francisco, California

COLORADO (Single PSRO Area)

Conditional		Colorado Foundation for Medical Care Denver, Colorado

CONNECTICUT (Four PSRO Areas)

Planning	Area 1	PSRO of Fairfield County, Inc. Bridgeport, Connecticut
	Area II	Connecticut Area II PSRO, Inc. New Haven, Connecticut
	Area III	Hartford County PSRO, Inc. Hartford, Connecticut

CONNECTICUT
(Continued)

Planning	Area IV	Eastern Connecticut PSRO, Inc. Willemantic, Connecticut
Support Center		Connecticut Medical Institute New Haven, Connecticut

DELAWARE (Single PSRO Area)

Planning	Delaware Foundation for Medical Care Wilmington, Delaware

DISTRICT OF COLUMBIA (Single PSRO Area)

Planning	National Capital Medical Foundation, Inc. Washington, D.C.

FLORIDA (Twelve PSRO Areas)

Planning	Area XII	Dade Monroe PSRO, Inc. Miami, Florida

GEORGIA (Single PSRO Area)

No contract awarded.

HAWAII (Also AMERICAN SAMOA, GUAM, TRUST TERRITORIES OF THE PACIFIC ISLANDS) (Single PSRO Area)

Planning	Pacific PSRO Honolulu, Hawaii

IDAHO (Single PSRO Area)

Planning	Idaho Foundation for Medical Care, Inc. Boise, Idaho

ILLINOIS (Eight PSRO Areas)		
Planning	Area III	Chicago Foundation for Medical Care Chicago, Illinois
	Area IV	Quad River Foundation for Medical Care Joliet, Illinois
INDIANA (Seven PSRO Areas)		
Planning	Area I	Calumet Professional Review Organization Highland, Indiana
	Area V	Indiana Area V PSRO Indianapolis, Indiana
Support Center		Indiana Physicians Support Agency Indianapolis, Indiana
IOWA (Single PSRO Area)		
Planning		The Iowa Foundation for Medical Care, Inc. West Des Moines, Iowa
KANSAS (Single PSRO Area)		
Planning		Kansas Foundation for Medical Care, Inc. Topeka, Kansas
KENTUCKY (Single PSRO Area)		
Planning		Kentucky Peer Review Organization, Inc. Louisville, Kentucky
LOUISIANA (Four PSRO Areas)		
No contract awarded.		

MAINE (Single PSRO Area)

Planning		Pine Tree Organization for Professional Standards Review, Inc. Waterville, Maine

MARYLAND (Seven PSRO Areas)

Planning	Area II	Baltimore City Professional Standards Review Organization, Inc. Baltimore, Maryland
	Area III	Montgomery County, Maryland Medical Care Foundation, Inc. Silver Spring, Maryland
	Area V	Central Maryland PSRO, Inc. Timonium, Maryland
	Area VI	Southern Maryland PSRO, Inc. Glen Burnie, Maryland
	Area VII	Delmarva Foundation for Medical Care, Inc. Salisbury, Maryland
Conditional	Area IV	Prince George's Foundation for Medical Care, Inc. Hyattsville, Maryland
Support Center		Maryland Foundation for Health Care Baltimore, Maryland

MASSACHUSETTS (Five PSRO Areas)

Planning	Area I	Western Massachusetts PSRO, Inc. Springfield, Massachusetts
	Area II	Central Massachusetts Health Care Foundation, Inc. Worcester, Massachusetts

MASSACHUSETTS
(Continued)

Planning	Area V	Southeastern Massachusetts PSRO, Inc. Middleboro, Massachusetts
Conditional	Area III	Charles River Health Care Foundation Newton Lower Falls, Massachusetts
	Area IV	Bay State PSRO, Inc. Boston, Massachusetts
Support Center		Massachusetts Statewide PSRO Support Center Boston, Massachusetts

MICHIGAN (Ten PSRO Areas)

Planning	Area I	Upper Peninsula Quality Assurance Association Executive Committee Escanaba, Michigan
	Area V	Genesee Medical Corporation Flint, Michigan
Support Center		Michigan State Medical Society East Lansing, Michigan

MINNESOTA (Three PSRO Areas)

Planning	Area III	Professional Services Quality Council of Minnesota Rochester, Minnesota
Conditional	Area II	Foundation for Health Care Evaluation Minneapolis, Minnesota

MISSISSIPPI (Single PSRO Area)

Conditional		Mississippi Foundation for Medical Care, Inc. Jackson, Mississippi

MISSOURI (Five PSRO Areas)

Planning	Area I	Northwest Missouri PSRO Foundation Kansas City, Missouri
	Area II	Mid-Missouri Foundation Jefferson City, Missouri
	Area III	Central Eastern Missouri Professional Review Organization Committee St. Louis, Missouri
	Area V	Southeast Missouri Foundation for Medical Care Cape Girardeau, Missouri
Support Center		Health Care Foundation of Missouri Jefferson City, Missouri

MONTANA (Single PSRO Area)

No contract awarded.

NEBRASKA (Single PSRO Area)

No contract awarded.

NEVADA (Single PSRO Area)

Planning	Nevada PSRO Reno, Nevada

NEW HAMPSHIRE (Single PSRO Area)

Planning	New Hampshire Foundation for Medical Care Concord, New Hampshire

NEW JERSEY (Eight PSRO Areas)

Planning	Area I	PSRO Region II Morristown, New Jersey

NEW JERSEY
(Continued)

Planning	Area II	Passaic Valley PSRO Clifton, New Jersey
	Area IV	Essex Physician Review Organization, Inc. East Orange, New Jersey
Support Center		New Jersey Foundation for Health Care Evaluation Trenton, New Jersey

NEW MEXICO (Single PSRO Area)

No contract awarded.

NEW YORK (Seventeen PSRO Areas)

Planning	Area I	Erie Region PSRO, Inc. Buffalo, New York
	Area II	Genessee Region PSRO, Inc. Rochester, New York
	Area III	PSRO of Central New York, Inc. Syracuse, New York
	Area IV	Five-County Organization for Medical Care & PSR New Hartford, New York
	Area V	Adirondack PSRO Glens Falls, New York
	Area IX	Area 9 PSRO of New York, Inc. Purchase, New York
	Area X	PSRO of Rockland Nanuet, New York
	Area XI	New York County Health Services Review Organization New York, New York
	Area XII	Richmond County, New York PSRO Staten Island, New York

NEW YORK
(Continued)

Planning	Area XIII	Kings County Health Care Review Organization Brooklyn, New York
	Area XV	Nassau Physicians Review Organization Garden City, New York
	Area XVI	The Bronx Medical Services Foundation, Inc. Bronx, New York
Support Center		Medical Society of the State of New York Lake Success, New York

NORTH CAROLINA (Eight PSRO Areas)

Planning	Area II	Piedmont Medical Foundation, Inc. Winston-Salem, North Carolina
Support Center		North Carolina Medical Peer Review Foundation, Inc. Raleigh, North Carolina

NORTH DAKOTA (Single PSRO Area)

No contract awarded.

OHIO (Twelve PSRO Areas)

Planning	Area I	Medco Peer Review, Inc. Cincinnati, Ohio
	Area II	Western Ohio Foundation for Medical Care Dayton, Ohio

OHIO
(Continued)

Planning	Area IV	Fourth Ohio Area PSR Council Toledo, Ohio
	Area VI	Region Six Peer Review Corporation Akron, Ohio
	Area X	Region X Peer Review Systems Corporation Columbus, Ohio
	Area XII	Physicians' Peer Review Organization Cleveland, Ohio
Support Center		Medical Advances Institute Columbus, Ohio

OKLAHOMA (Single PSRO Area)

No contract awarded.

OREGON (Two PSRO Areas)

Planning	Area II	Greater Oregon PSRO Portland, Oregon
Conditional	Area I	Multnomah Foundation for Medical Care Portland, Oregon

PENNSYLVANIA (Twleve PSRO Areas)

Planning	Area II	Central Pennsylvania Williamsport, Pennsylvania
	Area IV	Eastern Pennsylvania Health Care Foundation, Inc. Allentown, Pennsylvania
	Area VI	Allegheny PSRO Pittsburgh, Pennsylvania

PENNSYLVANIA (Continued)		
Planning	Area VII	Southwestern Pennsylvania PSRO Greensburg, Pennsylvania
	Area VIII	Highlands PSRO Corporation Johnstown, Pennsylvania
	Area IX	Southcentral Pennsylvania PSRO Lemoyne, Pennsylvania
	Area XI	Montgomery/Bucks PSRO, Inc. Norristown, Pennsylvania
	Area XII	Philadelphia PSRO Philadelphia, Pennsylvania
Support Center		Pennsylvania Medical Care Foundation Lemoyne, Pennsylvania
PUERTO RICO (Single PSRO Area)		
Planning		Foundation for Medical Care of Puerto Rico Santurce, Puerto Rico
RHODE ISLAND (Single PSRO Area)		
Planning		Rhode Island PSRO, Inc. (Ripsro, Inc.) Providence, Rhode Island
SOUTH CAROLINA (Single PSRO Area)		
Planning		South Carolina Medical Care Foundation Columbia, South Carolina
SOUTH DAKOTA (Single PSRO Area)		
Planning		South Dakota Foundation for Medical Care Sioux Falls, South Dakota

TENNESSEE (Two PSRO Areas)

Planning	Area I	Shelby County Foundation for Medical Care Memphis, Tennessee
Conditional	Area II	Tennessee Foundation for Medical Care Nashville, Tennessee

TEXAS (Nine PSRO Areas)

No contract awarded.

UTAH (Single PSRO Area)

Conditional	Utah PSRO Salt Lake City, Utah

VERMONT (Single PSRO Area)

Planning	Vermont PSRO Rutland, Vermont

VIRGIN ISLANDS (Single PSRO Area)

No contract awarded.

VIRGINIA (Five PSRO Areas)

Planning	Area II	Northern Virginia Foundation for Medical Care Alexandria, Virginia
Support Center		Virginia Professional Standards Review Foundation Charlottesville, Virginia

WASHINGTON (Single PSRO Area)

Planning	Washington State PSRO (WSPSRO) Seattle, Washington

WEST VIRGINIA (Single PSRO Area)

Planning		West Virginia Medical Institute, Inc. Charleston, West Virginia

WISCONSIN (Two PSRO Areas)

Planning	Area I	Wisconsin Professional Review Organization Madison, Wisconsin
	Area II	The Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc. Milwaukee, Wisconsin

WYOMING (Single PSRO Area)

Conditional	Wyoming Health Services Company, Inc. Cheyenne, Wyoming